

# San Diego County Black Infant Health (BIH) Program

5379 El Cajon Blvd • San Diego, CA 92115

## REFERRAL FORM

Please fax completed form to Barbara Greer at (619) 262-9188

OR e-mail to [barbarag@fhcsd.org](mailto:barbarag@fhcsd.org)

PERSON BEING REFERRED TO BIH (PLEASE PRINT CLEARLY)

<b>Last Name:</b>		<b>First Name:</b>		<b>Nickname/AKA/Maiden:</b>	
<b>Street Address:</b>			<b>City:</b>		<b>Zip Code:</b>
<b>Home Phone Number:</b>			<b>Cell Phone Number:</b>		
<b>Email Address:</b>				<b>Date of Birth:</b> ____/____/____	
<b>Please check one:</b> <input type="checkbox"/> <b>Pregnant</b> <b>Baby's Due Date:</b> ____/____/____ <input type="checkbox"/> <b>Parenting</b> <b>Baby's Birth Date:</b> ____/____/____					
<b>Additional Information:</b>					
<b>By signing below, I agree to be contacted by the San Diego County Black Infant Health Program.</b>					
<b>Client/Patient Signature:</b> _____				<b>Date:</b> _____	

### SOURCE OF REFERRAL TO BIH

**Referral Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name:** \_\_\_\_\_

**Organization Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Thank you for your referral to the BIH program.**

**For more information about BIH program services, please call (619) 266-7466.**

